UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Entresto

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Minimum age requirement 18 years old
- Diagnosis of systolic heart failure or-reduced left ventricular ejection fraction-
- Trial on an ACEI or an ARB
- Evidence of trial or currently receiving beta-blocker.
- NOT taking aliskiren (e.g. Tekturna or Tekturna HCT)
- NOT pregnant (if applicable)

AUTHORIZATION: 1 year

REAUTHORIZATION CRITERIA:

- Updated letter of medical necessity and evidence that patient is responding to treatment

REATHORIZATION: 1 year